EXHIBIT A

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KENTUCKY CERTIFICATE OF DEATH

116 201742985

Case #: E201712120117

To Be Completed By: Funeral Director (Must Be Typed)

1a. DECEDENT'S LEGAL NAME (First, Middle, Last) (Include AKA's if any): BEULAH MAE SLATTEN

1b. IF FEMALE, DECEDENT'S LAST NAME PRIOR TO FIRST MARRIAGE: TURNER

2. SEX: FEMALE

3. ACTUAL OR PRESUMED DATE OF DEATH (Month/Day/Year) (Spell Month): December 12, 2017

4. SOCIAL SECURITY NUMBER:

5a. AGE-LAST BIRTHDAY (Years): 68

5b. UNDER 1 YEAR: Months / Days

5c. UNDER 1 DAY: Hours / Minutes

6. DATE OF BIRTH (MM/DD/YYYY): 05/01/

7. COUNTY OF DEATH: FAYETTE

8. PLACE OF DEATH (Check only one): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ Dead on Arrival; OTHER: ☒ Hospice Facility ☐ Nursing Home/Long Term Care Facility ☐ Residence ☐ Other (Specify); Decedent's

9. FACILITY NAME (If not institution, give street and number): HOSPICE CARE CENTER

10. CITY OR TOWN, STATE AND ZIP CODE: LEXINGTON, KY 40504

11. BIRTHPLACE (City and State or Foreign Country): JACKSON, KENTUCKY

12. MARITAL STATUS: ☒ Married ☐ Widowed ☐ Never Married ☐ Married but Separated ☐ Divorced ☐ Unknown

13. SURVIVING SPOUSE (If wife, give name prior to first marriage): SCOTT SLATTEN

14. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life.) (Do not use retired): MONITOR

15. KIND OF BUSINESS/INDUSTRY: BUG

16. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No

17a. RESIDENCE - State: KENTUCKY

17b. COUNTY: FRANKLIN

17c. CITY OR TOWN: FRANKFORT

17d. STREET AND NUMBER: 3295 VERSAILLES RD APT #30

17e. ZIP CODE: 40601

17f. INSIDE CITY LIMITS? ☐ Yes ☒ No

18. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death.): ☐ 8th Grade or Less; ☐ 9th - 12th Grade, No Diploma; ☒ High School Graduate or GED Completed; ☐ Some College Credit but No Degree; ☐ Associates Degree (e.g., AA, AS); ☐ Bachelor's Degree (e.g., BA, AB, BS); ☐ Master's Degree (e.g., MA, MS, MEng, MEd, MSW, MBA); ☐ Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)

19. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if not Spanish/Hispanic/Latino.): ☒ No, not Spanish/Hispanic/Latino; ☐ Yes, Mexican, Mexican American, Chicano; ☐ Yes, Puerto Rican; ☐ Yes, Cuban; ☐ Yes, other Spanish/Hispanic/Latino (Specify)

20. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be.): ☒ White; ☐ Black or African American; ☐ Native Hawaiian; ☐ Asian Indian; ☐ Chinese; ☐ Filipino; ☐ Japanese; ☐ Guamanian or Chamorro; ☐ Korean; ☐ Vietnamese; ☐ Samoan; ☐ Other Asian (Specify); ☐ Other Pacific Islander (Specify); ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe); ☐ Other (Specify)

21. FATHER'S NAME (First, Middle, Last): FRED TURNER

22. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): EFFIE BARRETT

23a. INFORMANT'S NAME: SCOTT SLATTEN

23b. RELATIONSHIP TO DECEDENT: SPOUSE

23c. MAILING ADDRESS (Street and Number, City, State, Zip Code): 3295 VERSAILLES RD, 30, FRANKFORT, KY 40601

24. METHOD OF DISPOSITION (Check only one): ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)

25. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): ROSE CREST CEMETERY

26. LOCATION - City, Town, and State: VERSAILLES, KY

27. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such) (Must Use Blue/Black Ink): PENNY J. BAKER; DATE SIGNED (MM/DD/YYYY): 12/12/2017; Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.116

28. KY LICENSE NUMBER (for licensee): 6689

29. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: BLACKBURN & WARD FUNERAL HOME, 151 BROADWAY, VERSAILLES, KY 40383

To Be Completed By: Medical Certifier

30. DATE PRONOUNCED DEAD (MM/DD/YYYY): 12/12/2017

31. ACTUAL OR PRESUMED TIME OF DEATH: 0415

32. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☒ No

CAUSE OF DEATH

33. PART I. Enter the chain of events - diseases, injuries, or complications - that caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Sequentially list conditions, if any, leading to the cause listed on line a: DUE TO (OR AS A CONSEQUENCE OF): b.

Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST: DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death: a. -- YEAR(S)

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

34. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Homicide ☐ Pending Investigation ☐ Suicide ☐ Could not be Determined

35. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No

36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No

37. DID TOBACCO USE CONTRIBUTE TO DEATH? ☒ Yes ☐ Probably ☐ No ☐ Unknown

38. IF FEMALE: ☒ Not pregnant within past year ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Unknown if pregnant within past year

39. DATE OF INJURY (Month/Day/Year) (Spell Month):

40. TIME OF INJURY:

41. INJURY AT WORK? ☐ Yes ☐ No

42. PLACE OF INJURY (e.g., Residence; Home; construction site; restaurant; wooded area):

43. IF TRANSPORTATION INJURY, SPECIFY: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

44. DESCRIBE HOW INJURY OCCURRED:

45. LOCATION OF INJURY (Street and Number, City or Town, State, Zip Code):

46. TO BE COMPLETED BY CERTIFIER: To the best of my knowledge, death occurred at the time, date, and place, and due to cause(s) and manner stated.

SIGNATURE: SALLI E WHISMAN, MD (Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 and KRS 369.116

47. DATE CERTIFIED (MM/DD/YYYY): 12/13/2017

48. LICENSE NUMBER: 39706

49. TITLE OF CERTIFIER: PHYSICIAN

50. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (ITEM 33): SALLI WHISMAN, BLUEGRASS HOSPICE CARE (LEXINGTON), 2312 ALEXANDRIA DR, LEXINGTON, KY 40504

51. REGISTRAR'S SIGNATURE: Paul E. Rogers

52. DATE FILED (MM/DD/YYYY): 12/14/2017

FORM VS NO. 1-A (REVISED 08/2016)